Children with Special Health Care Needs (CSHCN) Services Program

PROVIDER ENROLLMENT APPLICATION

I. PROVIDER INFORMATION

Legal Name of Provider/Facility: _____

"Doing Business As" (DBA) Name, if applicable: _____

Physical Address: _____

Accounting Address: _____

Telephone Number: (____) _____ Employer's Tax ID #: _____

Medicaid Provider Number: _____ License Number: _____
(Please attach copy of current license, if applicable)

Please check type of service(s) provided:

- ☐ Psychologist
- ☐ Licensed Marriage & Family Counselor
- ☐ Licensed Professional Counselor
- ☐ Psychiatrist
- ☐ Licensed Master of Social Work / Advanced Clinical Practitioner
- ☐ Renal Dialysis Center
- ☐ Hospice
- ☐ Optometrist
- ☐ Optician
- ☐ Ophthalmologist
- ☐ Respiratory Therapist
- ☐ Certified Registered Nurse Anesthetist
- ☐ Family Nurse Practitioner
- ☐ Augmentative Communication Devices/systems
- ☐ I. P. Freestanding Psychiatric Facility

(For augmentative communication devices providers only)
Are you a current member of the Communication Aid Manufacturers Association (CAMA)? Yes___ No___

II. OWNERSHIP INFORMATION

(Please check appropriate box)

☐ Individual Recipient (not owning a business) Social Security #: _____

☐ Sole Ownership of Business
Owner's Name: _____ Social Security #: _____

☐ Partnership (If checked, please enter both partners' names and Social Security Numbers (SSN). If one of the partners is a corporation, use the corporation's Employer's Tax Identification Number (EIN)).

Name: _____ SSN/EIN: _____

Name: _____ SSN/EIN: _____

☐ Texas Corporation . . . . . If checked, please enter Texas Charter Number: _____

☐ Professional Association . . . . . If checked, please enter Texas Charter Number: _____

☐ Professional Corporation . . . . . If checked, please enter Texas Charter Number: _____

☐ Out of State Business: _____

☐ Other: _____

To the best of my knowledge, the information supplied on this document is accurate and complete and is hereby released to the Children with Special Health Care Needs Services Program for the purpose of issuing a CSHCN Provider Number.

_____

Signature

Title	Date

CHECK-OFF LIST FOR COMPLETE APPLICATIONS

☐ **Provider Enrollment Application completed, signed and dated**

☐ **Provider Agreement Form completed, signed and dated**

☐ **Copy of License submitted (if required)**

Please mail completed enrollment application to:

TDH/CSHCN Provider Enrollment
1100 West 49th Street
Austin, TX 78756-3179

Do Not Write In This Space
(For office use only)

CSHCN Local #_____ Enrollment Date _____

Status Date _____ Initials of Processor _____